

		FOR OHF USE					

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**2004**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2004)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0035352</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Rosewood Care Center of Peoria</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2003</u> to <u>6/30/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>1500 Northmoor Road</u> <u>Peoria</u> <u>61614</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>Peoria</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
<b>Telephone Number:</b> <u>(309) 637-2000</u> <b>Fax #</b> ( ) _____		<b>Paid Preparer</b> (Signed) <u>Accountant's Compilation Report Attached</u> _____ (Date) _____ (Print Name and Title) <u>Cindy A. Tefteller</u> _____ (Firm Name & Address) <u>C.J. Schlosser &amp; Company</u> _____ <u>233 East Center Drive, Alton, IL 62002</u> _____ (Telephone) <u>(618) 465-7717</u> <b>Fax #</b> <u>(618) 465-7710</u>																									
<b>IDPA ID Number:</b> <u>431446786001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>																									
<b>Date of Initial License for Current Owners:</b> <u>6/12/1989</u>																											
<b>Type of Ownership:</b> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Cindy A Tefteller</u> <b>Telephone Number:</b> <u>(618) 465-7717</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352 Report Period Beginning: 7/1/2003 Ending: 6/30/2004

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>12,021</u>	<u>12,021</u>	8
9	SNF/PED					9
10	ICF	<u>3,153</u>	<u>15,130</u>		<u>18,283</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,153</u>	<u>15,130</u>	<u>12,021</u>	<u>30,304</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 69.00%

D. How many bed-hold days during this year were paid by Public Aid?

54 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/12/1989

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/12/1989 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 58 and days of care provided 12,021Medicare Intermediary Tri-Span

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Rosewood Care Center of Peoria

# 0035352

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	185,047	17,023	8,277	210,347		210,347		210,347		1
2	Food Purchase		145,914		145,914		145,914	(5,628)	140,286		2
3	Housekeeping	119,828	34,891		154,719		154,719		154,719		3
4	Laundry	40,846	14,513		55,359		55,359		55,359		4
5	Heat and Other Utilities			114,307	114,307		114,307	11	114,318		5
6	Maintenance	25,741	20,376	80,749	126,866		126,866	10,324	137,190		6
7	Other (specify):* Sanitation			8,346	8,346		8,346		8,346		7
8	<b>TOTAL General Services</b>	371,462	232,717	211,679	815,858		815,858	4,707	820,565		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			23,274	23,274		23,274		23,274		9
10	Nursing and Medical Records	1,710,425	181,047	193,843	2,085,315		2,085,315		2,085,315		10
10a	Therapy	67,553	5,138	625,624	698,315		698,315	(361)	697,954		10a
11	Activities	50,884	3,533	2,600	57,017		57,017		57,017		11
12	Social Services	42,403	1,153	2,600	46,156		46,156		46,156		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,871,265	190,871	847,941	2,910,077		2,910,077	(361)	2,909,716		16
	<b>C. General Administration</b>										
17	Administrative			505,800	505,800		505,800	(406,200)	99,600		17
18	Directors Fees										18
19	Professional Services			3,950	3,950		3,950	31,648	35,598		19
20	Dues, Fees, Subscriptions & Promotions			25,816	25,816	4,400	30,216	(6,566)	23,650		20
21	Clerical & General Office Expenses	151,512	36,761	15,608	203,881		203,881	162,548	366,429		21
22	Employee Benefits & Payroll Taxes			286,346	286,346		286,346	25,583	311,929		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,603	5,603	(4,400)	1,203		1,203		24
25	Other Admin. Staff Transportation			7,332	7,332		7,332	12,732	20,064		25
26	Insurance-Prop.Liab.Malpractice			56,573	56,573		56,573	9,261	65,834		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	151,512	36,761	907,028	1,095,301		1,095,301	(170,994)	924,307		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,394,239	460,349	1,966,648	4,821,236		4,821,236	(166,648)	4,654,588		29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Rosewood Care Center of Peoria

#0035352

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			8,412	8,412		8,412	166,945	175,357			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,762	16,762		16,762	700,145	716,907			32
33	Real Estate Taxes			79,402	79,402		79,402	79,402	79,402			33
34	Rent-Facility & Grounds			1,200,510	1,200,510		1,200,510	(1,188,783)	11,727			34
35	Rent-Equipment & Vehicles			11,467	11,467		11,467		11,467			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,316,553	1,316,553		1,316,553	(321,693)	994,860			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		240,512	21,196	261,708		261,708		261,708			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		240,512	87,076	327,588		327,588		327,588			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,394,239	700,861	3,370,277	6,465,377		6,465,377	(488,341)	5,977,036			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 5

Facility Name & ID Number **Rosewood Care Center of Peoria**

# 0035352

Report Period Beginning: 7/1/2003

Ending: 6/30/2004

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,267)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,326)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(361)	2		13
14	Non-Care Related Interest	(16,757)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,591)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,338)	20		28
29	Other-Attach Schedule Marketing Salary	(67,424)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (104,064)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(384,277)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (384,277)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (488,341)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of PeoriaID# 0035352Report Period Beginning: 7/1/2003Ending: 6/30/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Eliminate Marketing Salary	\$ (67,424)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(67,424)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Rosewood Care Center of Peoria

# 0035352

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,628)	0	0	0	0	0	0	0	0	0	0	(5,628)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	11	0	0	0	0	0	0	0	0	11	5
6	Maintenance	0	0	10,324	0	0	0	0	0	0	0	0	10,324	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,628)</b>	<b>0</b>	<b>10,335</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,707</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(361)	0	0	0	0	0	0	0	0	0	(361)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(361)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(361)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(505,800)	99,600	0	0	0	0	0	0	0	0	(406,200)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	31,648	0	0	0	0	0	0	0	0	31,648	19
20	Fees, Subscriptions & Promotions	(7,929)	0	1,363	0	0	0	0	0	0	0	0	(6,566)	20
21	Clerical & General Office Expenses	(67,424)	0	229,972	0	0	0	0	0	0	0	0	162,548	21
22	Employee Benefits & Payroll Taxes	0	0	25,583	0	0	0	0	0	0	0	0	25,583	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	12,732	0	0	0	0	0	0	0	0	12,732	25
26	Insurance-Prop.Liab.Malpractice	0	0	9,261	0	0	0	0	0	0	0	0	9,261	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(75,353)</b>	<b>(505,800)</b>	<b>410,159</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(170,994)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(80,981)</b>	<b>(506,161)</b>	<b>420,494</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(166,648)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number    **Rosewood Care Center of Peoria**#    **0035352**

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	149,830	17,115	0	0	0	0	0	0	0	0	166,945	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(23,083)	723,228	0	0	0	0	0	0	0	0	0	700,145	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,200,510)	11,727	0	0	0	0	0	0	0	0	(1,188,783)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(23,083)</b>	<b>(327,452)</b>	<b>28,842</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(321,693)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(104,064)</b>	<b>(833,613)</b>	<b>449,336</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(488,341)</b>	<b>45</b>

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 505,800	HSM Management Services, Inc.	100.00%	\$	\$ (505,800)	1
2	V							2
3	V	10a Therapy	625,624	Rosewood Therapy Services, Inc.	0.00%	625,263	(361)	3
4	V							4
5	V	34 Rent	1,200,510	Peoria Real Estate, Inc.	0.00%		(1,200,510)	5
6	V	30 Depreciation		Peoria Real Estate, Inc.		149,830	149,830	6
7	V	32 Interest		Peoria Real Estate, Inc.		723,228	723,228	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,331,934			\$ 1,498,321	\$ * (833,613)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352Report Period Beginning: 7/1/2003Ending: 6/30/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 99,600	\$ 99,600	15
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	229,972	229,972	16
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	25,583	25,583	17
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	12,732	12,732	18
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	17,115	17,115	19
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	11,727	11,727	20
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	31,648	31,648	21
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	9,261	9,261	22
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	10,324	10,324	23
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	11	11	24
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	1,363	1,363	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 449,336	\$ * 449,336	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number      Rosewood Care Center of Peoria      #      0035352      Report Period Beginning:      7/1/2003      Ending:      6/30/2004

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00	703,530	2	6.13%	Salary	\$ 45,907	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00	415,899	2	6.13%	Salary	27,139	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 73,046		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352 Report Period Beginning: 7/1/2003Ending: 7/30/2004

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.Street Address 11701 Borman Drive, Suite 315City / State / Zip Code St. Louis, MO 63146Phone Number (314) 994-9070Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	82,623,207	18	\$ 1,192,475	\$ 5,061,164	\$ 73,046	1
2	21	Salaries - Others	Total Cost	82,623,207	18	3,339,865	5,061,164	204,587	2
3	22	Payroll Taxes	Total Cost	82,623,207	18	299,623	5,061,164	18,354	3
4	22	Employee Benefits	Total Cost	82,623,207	18	84,374	5,061,164	5,168	4
5	25	Travel	Total Cost	82,623,207	18	207,846	5,061,164	12,732	5
6	30	Depreciation	Total Cost	82,623,207	18	279,401	5,061,164	17,115	6
7	34	Building Rent	Total Cost	82,623,207	18	191,446	5,061,164	11,727	7
8	19	Professional Services	Total Cost	82,623,207	18	516,651	5,061,164	31,648	8
9	21	Telephone	Total Cost	82,623,207	18	181,396	5,061,164	11,112	9
10	26	Insurance	Total Cost	82,623,207	18	151,190	5,061,164	9,261	10
11	21	Taxes, Licenses, Ofc Sup	Total Cost	82,623,207	18	233,014	5,061,164	14,273	11
12	6	Maintenance	Total Cost	82,623,207	18	161,460	5,061,164	9,890	12
13	5	Heat & Other Utilities	Total Cost	82,623,207	18	178	5,061,164	11	13
14	20	Dues & Subscriptions	Total Cost	82,623,207	18	22,253	5,061,164	1,363	14
15	17	Direct - Admin	Direct Cost	1	1	26,554	1	26,554	15
16	17	Direct - Admin	Direct Cost	16	16	975,397	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	2,061	1	2,061	17
18	22	Direct - Payroll Taxes	Direct Cost	12	12	75,710	0	0	18
19	30	Direct - Depreciation	Direct Cost	1	1	0	1	0	19
20	30	Direct - Depreciation	Direct Cost	1	1	2,040	0	0	20
21	25	Direct - Travel	Direct Cost	1	1	0	1	0	21
22	25	Direct - Travel	Direct Cost	1	1	142	0	0	22
23	6	Direct - Maintenance	Direct Cost	1	1	434	1	434	23
24	6	Direct - Maintenance	Direct Cost	14	14	22,304	0	0	24
25	TOTALS					\$ 7,965,814	\$ 5,534,291	\$ 449,336	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Bank of America		X	Refinanced Mortgage	\$72,980.00	10/26/99	\$ 8,775,000	\$ 8,298,451	11/2009	8.8900	\$ 755,143	1	
2	Amortization of Loan Fees										15,257	2	
3	Less: Related Party Interest Offset										(47,172)	3	
4	Less: Interest Income Offset										(6,326)	4	
5												5	
	Working Capital												
6	Bank of America		X	Line of Credit	Varies		Draws as needed	\$ 0			5	6	
7												7	
8												8	
9	TOTAL Facility Related				\$72,980.00		\$ 8,775,000	\$ 8,298,451			\$ 716,907	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 8,775,000	\$ 8,298,451			\$ 716,907	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Rosewood Care Center of Peoria**# **0035352**

Report Period Beginning:

**7/1/2003**

Ending:

**6/30/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$ <b>72,939</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>74,596</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>1,657</b>	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>77,745</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>79,402</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999 <b>71,018</b>	8	
	2000 <b>74,207</b>	9	
	2001 <b>69,725</b>	10	
	2002 <b>72,217</b>	11	
	2003 <b>76,975</b>	12	
<b>2002 Payment - \$36,108</b>			
<b>2003 Payment - \$38,488</b>			
<b>Accrual = Balance of 2003 tax bill (\$38,487) + 1/2 of estimated 2004 tax bill (\$39,258)</b>			

	<b>FOR OHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Rosewood Care Center of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0035352

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-326-009</u>	<u>1500 W. Northmoor Road</u>	\$ <u>76,975.20</u>	\$ <u>76,975.20</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>76,975.20</u>	\$ <u>76,975.20</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet:

38,500

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	7.343 Acres	1989	\$ 212,793	1
2					2
3	TOTALS	#VALUE!		\$ 212,793	3

Facility Name &amp; ID Number Rosewood Care Center of Peoria

# 0035352

Report Period Beginning:

7/1/2003

Ending:

6/30/2004

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	120		1989	\$ 2,829,643	\$	15-25	\$ 117,876	\$ 117,876	\$ 1,916,639
5			1991	4,140		25	165	165	2,143
6			1992	7,309		5			7,309
7			1992	2,756		10			2,756
8									
<b>Improvement Type**</b>									
9	Legal, Arch, Eng, Contractor Fees		1989	32,140		25	1,286	1,286	19,397
10	Capitalized Interest		1989	15,100		25	604	604	9,110
11	Site Improvement, Sewers, Landscaping, Traffic Study		1989	306,686		15-25	14,191	14,191	218,343
12	Entry Concrete Slab		1990	6,197		20	310	310	4,110
13	Irrigation System		1993	10,125		25	405	405	4,489
14	Parking Lot Expansion		1994	3,475		25	139	139	1,367
15	Parking Lot Expansion		1995	56,648		25	2,266	2,266	19,450
16	Irrigation System		1995	2,029		25	81	81	695
17	Parking Lot		1997	39,664		25	1,587	1,587	11,903
18	Walk-in Cooler		1989	5,770		10			5,770
19	Sinks		1989	3,744		10			3,744
20	Exhaust Hood		1989	4,620		10			4,620
21	Fire Suppression System		1989	1,271		10			1,271
22	Generator		1989	14,937		10			14,937
23	Intercom System		1989	650		10			650
24	Facility Signs		1989	3,234		10			3,234
25	Baseboard Heaters		1989	672		10			672
26	Carpet		1989	7,664		10			7,664
27	Cubicle Track		1989	6,294		10			6,294
28	Sign		1991	3,733		10			3,733
29	Monument Sign		1992	1,737		10			1,737
30	Ceramic Sink		1994	2,011		10	201	201	1,943
31	Parking Lot Sealing & Striping		2004	21,277		25	496	496	496
32									
33	Leasehold Improvements - Facility								
34	Pave Driveway		1994	2,822		7			2,822
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	Painting/Baseboards/Carpeting	1995	\$ 33,169	\$	7	\$	\$	\$ 33,169	37
38	Cabinet Work	1995	1,868		7			1,868	38
39	Widen Activity Door	1996	2,659		7			2,659	39
40	Painting/Baseboards/Carpeting	1996	3,600	88	7	88		3,600	40
41	Carpeting/Undercounter Refig/Cabinets/Plants	1998	16,121	2,303	7	2,303		13,051	41
42	Wallpaper/Mini Blinds	1999	12,830	1,833	7	1,833		9,737	42
43	Ceiling Tiles	2000	991	140	7	140		529	43
44	Computer Cabling	2000	2,392	342	7	342		1,225	44
45	Door Alarm System	2000	3,143	449	7	449		1,721	45
46	Computer Receptacles	2001	214	31	7	31		107	46
47	Seal Parking Lot	2002	6,330	904	7	904		2,637	47
48	Painting	2003	3,167	452	7	452		641	48
49	Painting/Wallpaper	2004	6,220	74	7	74		74	49
50									50
51									51
52									52
53									53
54									54
55									55
56	Leasehold Improvements - Management Company:								56
57	Office Construction/Improvements	1995	469		5			469	57
58	Office Design	1995	43		5			43	58
59	Office Shelving	1996	100		4			100	59
60	Office Expansion	1996	443		4			443	60
61	Office Expansion	1997	1,185		3			1,185	61
62	Office Expansion	1998	669		3			669	62
63	Office Addition	1999	330		3			330	63
64	Door Locks	1999	165		3			165	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,492,456	\$ 6,616		\$ 146,223	\$ 139,607	\$ 2,351,720	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 172,906	\$ 1,796	\$ 21,521	\$ 19,725	5-10 Yrs	\$ 99,054	71
72	Current Year Purchases	22,367		630	630	5-10 Yrs	630	72
73	Fully Depreciated Assets	450,056					450,056	73
74								74
75	TOTALS	\$ 645,329	\$ 1,796	\$ 22,151	\$ 20,355		\$ 549,740	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management Services	Various	Various	\$ 35,128	\$	\$ 6,983	\$ 6,983	4 Yrs	\$ 13,765	76
77										77
78										78
79										79
80	TOTALS			\$ 35,128	\$	\$ 6,983	\$ 6,983		\$ 13,765	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,385,706	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,412	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 175,357	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 166,945	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,915,225	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$                      Description:                                     

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2005 \$                     

13.                      /2006 \$                     

14.                      /2007 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  <b>N/A - ONLY HIRE CERTIFIED AIDES</b> If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	27,776	\$ 275,580	\$	27,776	\$ 275,580	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		1,533	35,870		1,533	35,870	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		26,302	313,813	5,138	26,302	318,951	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				224,019		224,019	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12	Internal, Ambulance, X-Ray									12
13	Other (specify): & Lab Charges	39-8				21,196	16,493		37,689	13
14	TOTAL			\$	55,611	\$ 646,459	\$ 245,650	55,611	\$ 892,109	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 96,130	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,000 )	770,030		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,124		6
7	Other Prepaid Expenses	3,078		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 886,362	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	108,105		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(80,331)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 27,774	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 914,136	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 416,761	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,467		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,668		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,745		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,600		35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 627,241	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 627,241	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 286,895	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 914,136	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 275,222</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 275,222</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>175,773</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(164,100)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 11,673</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 286,895</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,933,330	1
2	Discounts and Allowances for all Levels	(2,715,086)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,218,244	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,532,317	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,532,317	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,700	13
14	Non-Patient Meals	5,267	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 9,967	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	6,326	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,326	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous	2,990	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,990	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,769,844	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	815,858	31
32	Health Care	2,910,077	32
33	General Administration	1,095,301	33
	<b>B. Capital Expense</b>		
34	Ownership	1,316,553	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	261,708	35
36	Provider Participation Fee	65,880	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,465,377	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	304,467	41
42	<b>Income Taxes</b>	(128,694)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 175,773	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center of Peoria# 0035352Report Period Beginning: 7/1/2003Ending: 6/30/2004

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,748	1,817	\$ 51,019	\$ 28.08	1
2	Assistant Director of Nursing	2,132	2,216	53,521	24.15	2
3	Registered Nurses	19,607	20,386	485,267	23.80	3
4	Licensed Practical Nurses	15,288	15,895	308,326	19.40	4
5	Nurse Aides & Orderlies	63,997	66,540	744,877	11.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,341	3,474	67,553	19.45	8
9	Activity Director					9
10	Activity Assistants	4,947	5,144	50,884	9.89	10
11	Social Service Workers	3,899	4,053	42,403	10.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,234	21,038	185,047	8.80	15
16	Dishwashers					16
17	Maintenance Workers	2,021	2,102	25,741	12.25	17
18	Housekeepers	14,912	15,505	119,828	7.73	18
19	Laundry	5,015	5,214	40,846	7.83	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,256	12,743	151,512	11.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,578	4,760	67,415	14.16	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,975	180,887	\$ 2,394,239 *	\$ 13.24	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	360	\$ 8,277	1-3	35
36	Medical Director	Contract	23,274	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	110	2,600	11-3	44
45	Social Service Consultant	105	2,600	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	575	\$ 36,751		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,037	\$ 37,283	10-3	50
51	Licensed Practical Nurses	4,707	156,263	10-3	51
52	Nurse Aides	9	297	10-3	52
53	TOTAL (lines 50 - 52)	5,753	\$ 193,843		53

SEE ACCOUNTANTS' COMPILATION REPORT

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Julie Schmidgall	Administrator	0.00%	\$ 13,930
Matt Nieukirk	Administrator	0.00%	12,624
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 26,554
<b>B. Administrative - Other</b>			
Description			Amount
Management Fees			\$ 505,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 505,800
<b>C. Professional Services</b>			
Vendor/Payee	Type		Amount
C.J. Schlosser & Company	Accountant/Consultant		\$ 3,950
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 3,950
<b>D. Employee Benefits and Payroll Taxes</b>			
Description			Amount
Workers' Compensation Insurance			\$ 50,140
Unemployment Compensation Insurance			40,629
FICA Taxes			182,886
Employee Health Insurance			8,056
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Management Company Allocations			25,583
Employee Physicals			1,991
Employee Uniforms			528
Employee Relations			2,116
TOTAL (agree to Schedule V, line 22, col.8)			\$ 311,929
<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			
Description	Line #		Amount
Section Not Applicable			\$
TOTAL			\$
<b>F. Dues, Fees, Subscriptions and Promotions</b>			
Description			Amount
IDPH License Fee			\$ 4,400
Advertising: Employee Recruitment			9,441
Health Care Worker Background Check (Indicate # of checks performed 84 )			1,008
Promotional Advertising			4,929
Misc. Dues/Subscriptions			7,438
Management Company Allocation			1,363
Less: Public Relations Expense			(688)
Non-allowable advertising			(903)
Yellow page advertising			(3,338)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 23,650
<b>G. Schedule of Travel and Seminar**</b>			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,203
Entertainment Expense			(
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,203

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Section Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center of Peoria**

STATE OF ILLINOIS

# **0035352**

Report Period Beginning: **7/1/2003**

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Ending: **6/30/2004**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association - \$6,480
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 62,787 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,880  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,267
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER INC. OF PEORIA  
IDPH ID #0035352  
ATTACHMENT TO SCHEDULE V, LINE 25  
6/30/2004

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 7,332</u>
	<u><u>\$ 7,332</u></u>

\*\*ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS  
SUBMITTED WHICH WERE LESS THAN \$250.00 EACH

ROSEWOOD CARE CENTER INC. OF PEORIA  
IDPH ID #0035352  
ATTACHMENT TO SCHEDULE VII, SECTION A.  
6/30/2004

RELATED NURSING HOME:

CITY:

ROSEWOOD CARE CENTER OF ALTON	ALTON, IL
ROSEWOOD CARE CENTER OF EAST PEORIA	EAST PEORIA, IL
ROSEWOOD CARE CENTER OF EDWARDSVILLE	EDWARDSVILLE, IL
ROSEWOOD CARE CENTER OF ELGIN	ELGIN, IL
ROSEWOOD CARE CENTER OF GALESBURG	GALESBURG, IL
ROSEWOOD CARE CENTER OF INVERNESS	INVERNESS, IL
ROSEWOOD CARE CENTER OF JOLIET	JOLIET, IL
ROSEWOOD CARE CENTER OF MOLINE	MOLINE, IL
ROSEWOOD CARE CENTER OF NORTHBROOK	NORTHBROOK, IL
ROSEWOOD CARE CENTER OF ROCKFORD	ROCKFORD, IL
ROSEWOOD CARE CENTER OF ST. CHARLES	ST. CHARLES, IL
ROSEWOOD CARE CENTER OF ST. LOUIS	ST. LOUIS, MO
ROSEWOOD CARE CENTER OF SWANSEA	SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:

TYPE OF BUSINESS:

HSM MANAGEMENT SERVICES, INC.	MANAGEMENT CO.
PEORIA REAL ESTATE, INC.	REAL ESTATE LSG.
HSM DEVELOPMENT, INC.	DEVELOPMENT CO.
RCC HOLDING COMPANY	HOLDING COMPANY
ROSEWOOD HOME HEALTH	HOME HEALTH CO.
ROSEWOOD THERAPY SERVICES	THERAPY COMPANY